Supreme Court, U.S.
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No. _____

In The

Supreme Court of the United States

October Term, 1996

DONNA DURHAM,

Petitioner,

vs.

HEALTH NET, a California Corporation, THE RESTAURANT ENTERPRISES GROUP INC. EMPLOYEE BENEFIT PLAN, et al.,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED FOR REVIEW

Whether the Ninth Circuit Court of Appeals decision denying Petitioner Durham a remedy either in the form of the value of medical treatment wrongfully withheld or in the form of equitable relief is in conflict with this Court's recent decision in *Varity Corp. v. Howe*, 516 U.S. ___, 116 S.Ct. 1065, 134 L.Ed.2d 130 (1996).

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PETITION FOR WRIT OF CERTIORARI

Petitioner Donna Durham respectfully prays that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Ninth Circuit in this case.

OPINIONS BELOW

The opinion of the Court of Appeals (App., *infra*, 1a-3a) is an unpublished decision, as is the memorandum and order of the United States District Court, Northern District of California (App., *infra*, 7a-14a).

JURISDICTION

The decision of the Court of Appeals was entered on February 10, 1997. (App. 1a) The jurisdiction of this Court is invoked under 28 U.S.C. Section 1254(1).

STATUTORY PROVISIONS INVOLVED

The statutory provisions at issue involve the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. Section 1001, et seq., and more specifically 29 U.S.C. Section 1132, which governs civil actions which may be brought for remedies under the Act. (App. 16a)

STATEMENT OF THE CASE

Petitioner Donna Durham was a thirty-eight year old waitress, who was married and supporting her three young children at the time she discovered a suspicious lump in her breast in July of 1992. Durham immediately sought medical treatment, and in September, 1992, she underwent a lumpectomy which revealed that she was suffering from an extremely advanced form of infiltrating ductal carcinoma of the breast. Following a mastectomy, Durham's treating oncologists strongly recommended that she undergo aggressive treatment consisting of high dose chemotherapy supported by autologous bone marrow transplantation/peripheral stem cell reinfusion (hereinafter "HDCT with ABMT").[1] This treatment was recommended by Ms. Durham's physicians as her best available care option and as her only hope for a potential

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[1] HDCT with ABMT involves the use of high doses of powerful chemotherapy in keeping with the scientifically accepted principle that the higher the doses of chemotherapy medications which can be administered, the greater the cancer-kill rate which can be achieved. Because, however, such dosages also destroy bone marrow, before the administration of HDCT, the patient's own bone marrow is harvested and stored. Without bone marrow, the body is unable to produce blood cells and is highly susceptible to infection and hemorrhaging. By reinfusing the previously harvested bone marrow after administration of the HDCT, the patient's bone marrow is replenished and the patient's auto-immune and clotting systems can be revitalized. Nevertheless, there is only a brief window of opportunity after the patient completes a course of conventional chemotherapy in which HDCT with ABMT can be accomplished. Unless the procedure is approved *and* administered during this relatively brief time period, the patient loses the opportunity to receive this critical treatment.

cure and long-term survival. Thus, in November of 1992, Durham requested coverage for HDCT with ABMT from Respondent Health Net, the Health Maintenance Organization ("HMO") for the Restaurant Enterprises Group Inc. Employee Benefit Plan of which Ms. Durham was a member.

Health Net, however, denied Durham's request, based on its determination that the treatment was "investigational." Thereafter, Durham sought a second opinion from another oncologist who also recommended that she receive HDCT with ABMT as soon as possible. Because Durham was informed by her physicians that there was only a small window of opportunity within which she could receive this potentially life-saving and medically necessary treatment, in March of 1993, Durham again notified Health Net of these exigent circumstances and requested immediate approval for the procedure. Yet despite the recommendations of both oncologists, Health Net again denied coverage, this time on the grounds that it was not "medically necessary."

Durham was in no position to cover the costs of the treatment (which can range from $125,000 to $200,000) from her personal financial resources. Consequently, she was unable to receive the treatment during the critical window of opportunity dictated by her progressing medical condition. Thus, this door to a potentially life-saving treatment was closed to Durham.

On March 16, 1994, Durham filed an action against Health Net in the Superior Court of California, stating causes of action for breach of contract, bad faith, fraud and emotional distress. On October 11, 1994, Health Net

removed the action to the United States District Court, Northern District of California.[2] On January 31, 1995, Durham filed a First Amended Complaint for breach of the employee welfare benefit plan and for recovery of plan benefits, for equitable relief and for attorney's fees. Respondents filed an answer to the First Amended Complaint on February 21, 1995. Both sides thereafter filed motions for summary judgment with supporting documents, including a Joint Statement of Undisputed Facts. (App. 4a)

On June 22, 1995, the district court granted respondents' motions for summary judgment and adjudication and denied Durham's motions for summary judgment. (App. 7a) Judgment was entered on July 10, 1995. (App. 15a)

Following appeal to the Ninth Circuit Court of Appeals, that court issued an unpublished memorandum decision on February 10, 1997, affirming the decision of the district court.[3] (App. 1a) This petition for writ of certiorari follows.

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[2] Thus, jurisdiction in the district court was premised on the existence of federal questions (28 U.S.C. Section 1331), while jurisdiction in the Ninth Circuit Court of Appeals was based upon the final decision emanating from the district court (28 U.S.C. Section 1291).

[3] Shortly before oral argument at the Ninth Circuit Court of Appeals, Donna Durham's cancer reappeared. Thus, as both her oncologists had warned, the standard course of chemotherapy, without HDCT-ABMT, has proved tragically insufficient.

REASONS FOR GRANTING THE PETITION

THE DECISION OF THE NINTH CIRCUIT COURT OF APPEALS CONFLICTS WITH THIS COURT'S DECISION IN *VARITY CORP. V. HOWE* AND WITH THE UNDERLYING PURPOSES OF ERISA.

I. THE DECISION IN *VARITY* CLEARLY SUPPORTS THE FASHIONING OF APPROPRIATE EQUITABLE RELIEF PURSUANT TO 29 U.S.C. SECTION 1132(a)(3) WHERE NO OTHER ADEQUATE RELIEF IS OTHERWISE AVAILABLE UNDER SECTION 1132(a).

As stated in Supreme Court Rule 10, among the considerations which govern review on certiorari are the circumstances wherein "a United States court of appeals has decided an important question of federal law . . . in a way which conflicts with relevant decisions of this Court." Petitioner Durham submits that such circumstances are presented here.

Until this Court's decision in *Varity Corp. v. Howe*, 516 U.S. ___, 116 S.Ct. 1065, 134 L.Ed.2d 130 (1996), federal courts routinely rejected claims for equitable relief on behalf of individual plan members on the grounds that the equitable relief provision of 29 U.S.C. Section 1132(a)(3) inured only to the benefit of the plan as a whole, and not to individual members.

In *Varity*, however, this Court had occasion to address this very issue and squarely held that the limitation which had been read into 29 U.S.C. Section 1132(a)(3) was simply insupportable.

As this Court stated, although the provisions of ERISA which set forth general fiduciary duties which

"draw much of their content from the common law of trusts," nevertheless:

> We also recognize, however, that trust law does not tell the entire story. After all, ERISA's standards and procedural protections partly reflect a congressional determination that the common law of trusts *did not offer completely satisfactory protection*. . . . And, even with respect to the trust-like fiduciary standards ERISA imposes, Congress 'expect[ed] that the courts will interpret this prudent man rule (and other fiduciary standards) bearing in mind the special nature and purpose of employee benefit plans,' . . . as they 'develop a federal common law of rights and obligations under ERISA-regulated plans.' . . .
>
> Consequently, we believe that the law of trusts often will inform, but will not necessarily determine the outcome of an effort to interpret ERISA's fiduciary duties. In some instances, trust law will offer only a starting point, after which courts *must go on to ask whether, or to what extent, the language of the statute, its structure, or its purposes require departing from common-law trust requirements.*

Varity, 516 U.S. ___, 116 S.Ct. at 1070; emphasis added.

With these precepts in mind, yet with due awareness of the "competing congressional purposes" of the legislature's desire to offer employees *enhanced* "protection for their benefits" without creating a system so complex that it would unduly discourage employers from offering benefit plans, this Court turned to the question of statutory interpretation of 29 U.S.C. Section 1132(a)(3). *Ibid.*

As the Court stated:

> We are aware, as Varity suggests, of one possible reason for a departure from ordinary trust law principles. In arguing about ERISA's remedies for breaches of fiduciary obligation, Varity says that Congress intended ERISA's fiduciary standards to protect only the financial integrity of the plan, not individual beneficiaries. This intent, says Varity, is shown by the fact that Congress did not provide remedies for individuals harmed by such breaches; rather Congress limited relief to remedies that would benefit only the plan itself. This argument fails, however, because, in our view, Congress *did* provide remedies for individual beneficiaries harmed by breaches of fiduciary duty, as we shall next discuss.

Varity, 516 U.S. ___, 116 S.Ct. at 1075; emphasis in original.

The specific provision under consideration was Section 502(a) of the Act, codified at 29 U.S.C. Section 1132(a). That section governs who may bring a civil action under ERISA for various forms of relief, and at subsection (a)(3) provides:

> (a) A civil action may be brought –
>
> (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) *to obtain other appropriate equitable relief* (i) to redress such violation or (ii) to enforce any provision of this subchapter or the terms of the plan; . . .

29 U.S.C. § 1132(a)(3); emphasis added.

When presented with Varity's contention that because subsection (a)(2) of Section 1132 made specific reference to the relief available under Section 409 (entitled "Liability for Breach of Fiduciary Duty"), it operated as a limitation on the "appropriate equitable relief" available under Section 1132(a)(3), this Court responded, "Yet, in this case, why should one believe that Congress intended the specific remedies in § 409 as a *limitation*?" *Varity*, 516 U.S. ___, 116 S.Ct. at 1077; emphasis in original. As the Court went on to state:

> To the contrary, one can read § 409 as reflecting a special congressional concern about plan asset management without also finding that Congress intended that section to contain the exclusive set of remedies for every kind of fiduciary breach. After all, ERISA makes clear that a fiduciary has obligations other than, and in addition to, managing plan assets. . . . For example, as the dissent concedes, . . . a plan administrator engages in a fiduciary act when making a discretionary determination about whether a claimant is entitled to benefits under the terms of the plan documents. . . . And, as the Court pointed out in *Russell*, 473 U.S. at 144, ERISA specifically provides a remedy for breaches of fiduciary duty with respect to the interpretation of plan documents and the payment of claims, one that is outside the framework of the *second* subsection and cross-referenced § 409, and one that runs directly to the injured beneficiary. § 502(a)(1)(B) . . . Why should we not conclude that Congress provided yet other remedies for yet other breaches of the sorts of fiduciary obligation in another 'catchall' remedial section?

Varity, 516 U.S. ___, 116 S.Ct. at 1077; emphasis in original.

In answering this question, this Court noted that such a "catchall" reading of subsection (a)(3) was entirely consistent with the overall structure of Section 502(a) (29 U.S.C. § 1132(a)), wherein four of its six subsections focus on specific areas of concern, while:

> The language of the other two subsections, the third and the fifth, creates two 'catchalls,' providing 'appropriate equitable relief' for 'any' statutory violation. This structure suggests that these 'catchall' provisions *act as a safety net, offering relief for injuries caused by violations that § 502 does not elsewhere adequately remedy*. And, contrary to Varity's argument, *there is nothing in the legislative history that conflicts with this interpretation.*

Varity, 516 U.S. ___, 116 S.Ct. at 1077-1078; emphasis added.

Furthermore, as this Court emphasized, "ERISA's basic purposes favor a reading of the *third* subsection that provides the plaintiffs with a remedy," since the articulated statutory purpose of ERISA is to "protect . . . the interests of participants . . . by establishing standards of conduct, responsibility, and obligations of fiduciaries" and to provide "appropriate remedies" where such interests are infringed. *Ibid;* emphasis in original. As the Court concluded:

> Given these objectives, it is hard to imagine why Congress would want to immunize breaches of fiduciary obligation that *harm individuals by denying injured beneficiaries a remedy.*

Ibid; emphasis added.

In response to the concerns raised by *amici* supporting Varity as to the purported adverse consequences

which would follow an extension of fiduciary obligations to individuals, this Court noted several reasons why such concerns seemed "unlikely to materialize," including the recognition in the law of trusts that "the need to preserve assets" requires a trustee to "take impartial account of the interests of all beneficiaries" and that "characterizing a denial of benefits as a breach of fiduciary duty does not necessarily change the standard a court would apply when reviewing the administrator's decision to deny benefits." Finally, the Court noted that "the statute authorizes *'appropriate'* equitable relief." *Varity*, 516 U.S. ___, 116 S.Ct. at 1078-1079; emphasis in original. Thus, this Court stated that:

> We should expect that courts, *in fashioning* 'appropriate' equitable relief, will keep in mind the 'special nature and purpose of employee benefit plans', and will respect the 'policy choices reflected in the inclusion of certain remedies and the exclusion of others.' [Citations omitted.] Thus, we should expect that *where Congress elsewhere provided adequate relief for a beneficiary's injury*, there will likely be no need for *further* equitable relief, in which case such relief would normally not be 'appropriate.'

Varity, 516 U.S. ___, 116 S.Ct. at 1079; emphasis added.

Significantly, however, this Court went on to explain:

> But that is not the case here. The plaintiffs in this case could not proceed under the *first* subsection because they were no longer members of the Massey-Fergusen plan and, therefore, had no 'benefits due [them] under the terms of [the] plan.' § 502(a)(1)(B). They could not proceed under the *second* subsection because

> that provision, tied to § 409, does not provide a remedy for individual beneficiaries. . . . They must rely on the *third* subsection or they have no remedy at all. We are not aware of any ERISA-related purpose that denial of a remedy would serve. Rather we believe that granting a remedy is consistent with the literal language of the statute, the Act's purposes, and pre-existing trust law.

Varity, 516 U.S. ___, 116 S.Ct. at 1079; emphasis in original.

Thus, in *Varity*, the individual right to seek equitable relief under ERISA was firmly acknowledged.

II. WHERE THE RELIEF ACCORDED UNDER 29 U.S.C. SECTION 1132(a)(1)(B) IS EITHER UNAVAILABLE OR INADEQUATE, UNDER *VARITY* THE QUESTION OF APPROPRIATE RELIEF UNDER SECTION 1132(a)(3) IS SQUARELY PRESENTED.

In considering *Varity's* relevance and application to the instant case, several factors are significant. Indeed, this case amply illustrates the difficulties involved in applying a statutory scheme initially devised to protect employees' retirement income in the health care management context. Where it is pension benefit funds which are delayed or denied, no doubt the plan member is harmed by the loss of the anticipated use of such funds. Yet the remedy provided under 29 U.S.C. Section 1132(a)(1)(B) provides an *adequate* remedy by according the plan participant or beneficiary the right to pursue a civil action:

> [T]o recover benefits due to him under the terms of the plan, to enforce his rights under the

> terms of the plan, or to clarify his rights to future benefits under the terms of the plan.

29 U.S.C. § 1132(a)(1)(B).

Consider, however, the circumstance wherein the "benefits" involved are not cash payments of pension benefits, nor even monetary coverage for medical treatment already received, but instead the medical treatment *itself*,[4] a treatment urgently recommended by the individual's treating physicians and which must be administered within a narrow window of time in order to be of any medical value at all. Under these circumstances, even if it is subsequently determined that the initial refusal or delay was unequivocally erroneous, there is, under 29 U.S.C. Section 1132(a)(1)(B) clearly no truly "adequate" remedy. Even the belated provision of a monetary award equivalent to the cost of the treatment would be cold comfort indeed to one who has irretrievably lost, through mere lapse of time, the opportunity for this life-saving treatment.

Yet, as decided by the Ninth Circuit Court of Appeals, a person in Durham's situation is without a remedy under 29 U.S.C. Section 1132(a)(1)(B). As characterized by that court:

> This provision allows only for recovery of accrued benefits, a declaratory judgment that the person is entitled to benefits, and an injunction to prevent a plan administrator from wrongly refusing to pay benefits in the future. *Massachusetts Mut. Life Ins. Co. v. Russell*, 473

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[4] Such a contract contrasts dramatically with the usual contract for economic advantage. Here, the ostensible benefit of the contract to one such as Durham was her peace of mind, her health, her life.

> U.S. 134, 146-147 (1985). This section does not include an implied action for recovery of damages for delay in the processing of a disputed claim. 473 U.S. at 145.

(App. 2a)

In answer to Durham's argument that she was not seeking compensatory damages for the"delay" in provision of the treatment, but rather the denied benefit itself in the only form now available to her, i.e., an amount equivalent to the cost of treatment as of the time the treatment was denied, the Ninth Circuit Court of Appeals stated flatly:

> There is no authority found in the words of the statute, its legislative history, or the case law, which would allow a recovery for the value of withheld medical treatment under this section.

(App. 2a-3a)

In other words, according to the decisions below, there *is* no remedy which applies in Durham's circumstances under 29 U.S.C. Section 1132(a)(1)(B).[5]

It should be noted that as the legal issues were framed below, the question presented both to the district court and the court of appeals was the "threshold issue" of "whether Health Net can be held liable for its refusal to cover the treatment if in fact its refusal was arbitrary

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[5] In short, where the benefit involved is the treatment itself, and the HMO breaches the contract by wrongfully denying or delaying the treatment until it is no longer medically feasible to administer HDCT with ABMT, the HMO is granted absolute immunity for its breach.

and capricious." Thus, the primary focus below was upon whether Durham had any recourse under Section 1132(a)(2)(B) *as a matter of law* once she was no longer a condidate for HDCT-ABMT, even if the refusal of treatment was indeed arbitrary, capricious and therefore assumed to be a breach. (App. 8a) This question was answered in a formulaic manner by both the district and appellate courts. As the district court stated:

> . . . [T]he benefit referred to in this section of ERISA consists either of the accrued costs of the benefit or the benefit itself. . . . Because Durham did not obtain the treatment, she has not accrued recoverable costs. Because she is no longer a candidate for the treatment, she cannot obtain the treatment as a form of relief.

(App. 11a-12a)

Although the district court asserted that "Durham was not left without legal recourse if indeed she was wrongly denied benefits," because she purportedly "had the option of obtaining an injunction or a declaratory judgment to receive the HDCT-ABMT treatment during the time it would have benefitted her" (App. 12a), it is manifestly apparent that this was insupportable speculation. Again, the reality is that Durham, and others like her who are in immediate need of HDCT-ABMT, have only a limited window of time (App. 8a) within which the treatment can be administered if it is to have any medical benefit. The "adequacy" of the alternative forms of relief of declaratory judgment or injunctive relief assumes that the patient will not only learn of the medical necessity of such treatment *and* the HMO's intention to refuse treatment in a timely fashion, but will further immediately be able to obtain counsel to pursue injunctive or declaratory

relief, and that such legal remedies will necessarily be litigated and made available *within* the narrow window of time dictated by the patient's unpredictable medical status.

There is simply no logical basis to make such factual assumptions, and indeed, given the devastating immediate consequences of a diagnosis of advanced cancer, there is every reason to expect that an individual in such circumstances will not be in a position to immediately and expeditiously seek legal remedies, remedies which he or she may not even be aware of until the critical treatment has *already* been denied, only after the necessity for legal counsel has been realized, and only after legal representation is ultimately obtained. Consequently, the purported availability of an "adequate" remedy under 29 U.S.C. Section 1132(a)(1)(B) is in fact illusory.

Since it is not in dispute that a participant may, under Section 1132(a)(1)(B) obtain *reimbursement* for personal expenditures for medical treatment wrongfully denied by an HMO, the upshot of the decision below is that only those fortunate few who have the financial resources to obtain the costly critical treatment of HDCT with ABMT on their own will thereafter be able to pursue a monetary recovery under this provision. For the overwhelming majority, however, this option is simply unavailable. Thus, the "adequacy" of this form of relief is limited to a minuscule fraction of affected individuals, while for the vast majority such a "remedy" is nothing more than a cruel irony.

It is the position of the petitioner herein that an interpretation of 29 U.S.C. Section 1132(a)(1)(B) which accords relief only to the independently wealthy, or to

those limited few whose physical and financial circumstances only *fortuitously* permit them the opportunity to obtain treatment within the unpredictable window of time dictated by the nature of their illness, is unjust and insupportable. To accord relief for an arbitrary and capricious denial of medical treatment only under such equally arbitrary circumstances, and yet label the available legal remedies "adequate" is a travesty. As this case demonstrates, the actual practical result is that merely because Durham "is no longer a candidate for the treatment, . . . , she does not have legal recourse under section [1132](a)(1)(B)." (App. 12a) If all that an HMO need do in order to insulate itself from virtually all legal consequences for a wrongful breach is to merely delay its decision until the patient is no longer a candidate, then the law itself is supplying the *incentive* to wrongfully delay and deny.

If, however, as the district court and appellate court concluded, there is indeed no *adequate* remedy for Durham under 29 U.S.C. Section 1132(a)(1)(B), then the question of her entitlement to equitable relief under 29 U.S.C. Section 1132(a)(3) comes into critical focus.

As this Court stated in *Varity*, "a plan administrator engages in a fiduciary act when making a discretionary determination about whether a claimant is entitled to benefits," and, contrary to previous interpretations of 29 U.S.C. Section 1132(a)(3), that section operates "as a safety net, offering relief for injuries caused by violations that § 502 [§ 1132] does not elsewhere *adequately* remedy." *Varity*, 516 U.S. ___, 116 S.Ct. at 1077-1078; emphasis added. Where a benefit in the form of time-sensitive medical treatment is arbitrarily and capriciously denied,

and the individual is foreclosed from any adequate remedy under the remaining provisions of 29 U.S.C. Section 1132(a), then, clearly, the question of whether some form of appropriate relief can be fashioned pursuant to Section 1132(a)(3) is squarely presented. Here, as in *Varity*, unless Durham has recourse to this third subsection, she has no recourse at all. *Varity*, 516 U.S. ___, 116 S.Ct. at 1079.

III. WHERE THE DECISION OF THE LOWER APPELLATE COURT OPERATES TO IMMUNIZE ARBITRARY AND CAPRICIOUS VIOLATIONS OF THE FIDUCIARY DUTY TO INDIVIDUAL PARTICIPANTS AND BENEFICIARIES, REVIEW BY THE SUPREME COURT IS NECESSARY.

The Ninth Circuit Court of Appeals gave only the most cursory attention to this profoundly important issue. Concluding that petitioner Durham was "essentially seeking an award of damages," the appellate court merely noted that it had "recently considered the scope of relief available under § 502(a)(3)" and had "precluded an award of compensatory damages under that section." (App. 3a) The case relied upon by the Ninth Circuit court, *McLeod v. Oregon Lithoprint Inc.*, 102 F.3d 376 (9th Cir. 1996), is, however, clearly distinguishable:

> The relief which McLeod seeks is not 'equitable relief.' She does not seek an injunction, mandamus *or restitution*. The complaint does not allege fraud on the part of the plan fiduciaries. *There is no allegation of a fund which was wrongfully withheld from McLeod*. The basis of her complaint is that the fiduciaries failed to notify her in a timely manner of her right to elect cancer coverage. This is in essence a negligence claim,

> for which she seeks to be made whole through an award of money damages equal in amount to the benefits she would have been paid and *compensation* for her emotional distress.

McLeod, 102 F.3d at 378; emphasis added.

Here, by contrast, Durham expressly *did* seek restitution, or, alternatively, an imposition of a constructive trust or disgorgement of the value of the benefits wrongfully denied as unjust enrichment. All such remedies are quintessentially equitable in nature and are not transmuted into "compensatory damages" merely because the form of the equitable remedy involves a determined monetary amount.

If there is no adequate remedy for Durham, and others like her, to be found elsewhere in 29 U.S.C. Section 1132(a), the ultimate question of whether appropriate equitable relief can be fashioned pursuant to Section 1132(a)(3) for an arbitrary or capricious denial of benefits cannot be passed off merely by labeling any potential monetary form of relief "compensatory" rather than equitable in nature. Such a dismissive circumvention of the real issue is contrary to the underlying purpose of ERISA, which is to provide *enhanced* protection for an individual's benefits, not a cruel dilemma in which time sensitive life-saving medical treatment can be denied, or merely delayed until such time as the participant is no longer a candidate, with no recourse whatsoever provided for such arbitrary conduct.

As this Court made clear in *Varity*, the fiduciary obligations imposed under ERISA run to individual participants and beneficiaries as well as to the financial

integrity of the plan as a whole. A decision such as was reached herein, which literally immunizes, as a matter of law, even an arbitrary and capricious denial or delay in critical medical treatment, is fundamentally at odds with *Varity* and with the congressional intent which informs ERISA. With the growing expansion of managed health care throughout the United States, this case presents issues of federal statutory interpretation of profound importance which warrant review by this Court.

CONCLUSION

For the foregoing reasons, Petitioner Donna Durham prays that the requested writ of certiorari be granted.

DATED: May 9, 1997.

Respectfully submitted,

LAW OFFICES OF LEIBOVIC & TYSCH
GARY L. TYSCH,
Counsel for Petitioner
Donna Durham

NOT FOR PUBLICATION

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

DONNA DURHAM Plaintiff-Appellant, v. HEALTH NET, a California corporation; THE RESTAURANT ENTERPRISES GROUP INC. EMPLOYEE BENEFIT PLAN; DOES 1 through 30, inclusive, Defendants-Appellees.	No. 95-16585 D.C. No. CV-94-03575-MHP **MEMORANDUM***

(Original Filed May 19, 1995)

(Filed Feb. 10, 1997)

Appeal from the United States District Court
for the Northern District of California
Marilyn H. Patel, District Judge, Presiding

Argued and Submitted November 8, 1996
San Francisco, California

Before: HUG, Chief Judge, REAVLEY** and LEAVY, Circuit Judges.

Donna Durham ("Durham") appeals from a summary judgment in favor of her health plan provider, Health Net. She claims that Health Net breached its obligations under her benefit plan when it refused to authorize a

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* This disposition is not appropriate for publication and may not be cited to or by the courts of this circuit except as provided by the Ninth Circuit Rule 36-3.

** Honorable Thomas M. Reavley, Senior United States Circuit Judge for the Fifth Circuit, sitting by designation.

high dose chemotherapy and a bone marrow transplant for treatment of her breast cancer. Durham seeks relief under the Employee Retirement Income Security Act ("ERISA"), § 502(a)(1)(B) and § 502(a)(3), codified at 29 U.S.C. §§ 1132(a)(1)(B), 1132(a)(3).

In count one of her complaint, Durham seeks recovery of plan benefits under ERISA § 502(a)(1)(B).[1] This provision allows only for recovery of accrued benefits, a declaratory judgment that the participant is entitled to benefits, and an injunction to prevent a plan administrator from wrongly refusing to pay benefits in the future. *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146-147 (1985). This section does not include an implied action for recovery of damages for delay in the processing of a disputed claim. 473 U.S. at 145.

Durham argues that she is not seeking damages in count one, but rather she is seeking only the cost of treatment at the time the treatment was wrongfully refused. There is no authority, found in the words of the statute, its legislative history, or the case law, which

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[1] 29 U.S.C. § 1132(a)(1)(B) provides:

A civil action may be brought –

(1) by a participant or beneficiary –

. . .

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

. . .

would allow a recovery for the value of withheld medical treatment under this section.

In count two of her complaint, Durham seeks equitable claims for restitution, constructive trust, and unjust enrichment under ERISA § 502(a)(3).[2] Again, there is no authority to support these equitable claims when disputed medical benefits are delayed or withheld. Durham is essentially seeking an award of damages equal in amount to the medical benefits which she claims were wrongfully withheld. We recently considered the scope of relief available under § 502(a)(3) and have precluded an award of compensatory damages under that section. *See McLeod v. Oregon Lithoprint,* 102 F.3d 376 (1996 WL 729600) (9th Cir. 1996).

The district court's order granting summary judgment to defendants-appellees is AFFIRMED.

---

[2] 29 U.S.C. § 1132(a)(3) provides:

(a) A civil action may be brought –

. . . (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) *to obtain other appropriate equitable relief* (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan. (emphasis added).

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IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

DONNA DURHAM Plaintiff, vs. HEALTH NET, a California corporation; THE RESTAURANT ENTERPRISES GROUP INC. EMPLOYEE BENEFIT PLAN and DOES 1 through 100, inclusive, Defendants.	CASE NO. C94 3575 MHP JOINT STATEMENT OF UNDISPUTED FACTS Date: June 16, 1995 Time: 10:30 a.m. Dept.: 11 Hon. M. Hall Patel (Filed May 19, 1995)

Pursuant to the order of the Court, the parties hereby submit this Joint Statement of Undisputed Facts in connection to their cross Motions for Summary Judgment:

1. Plaintiff, DONNA DURHAM, first became a HEALTH NET member on January 1, 1992.

2. Plaintiff, DONNA DURHAM, received her HEALTH NET coverage as a benefit of employment at Restaurant Enterprises Group, Inc.

3. The plan of benefits herein is governed under the provision of Employee Retirement Income & Security act of 1974 ("ERISA"), 29 U.S.C. §1002 et seq.

4. Plaintiff's employment at Restaurant Enterprises Group, Inc. terminated on June 15, 1992.

5. Thereafter, Plaintiff, DONNA DURHAM, exercised her right to continue her HEALTH NET coverage under provisions of COBRA.

6. Plaintiff, DONNA DURHAM, was diagnosed with breast cancer on September 14, 1992.

7. Plaintiff made a request to HEALTH NET for coverage of high dose chemotherapy treatment/autologous bone marrow transplant ("HDCT/ABMT") in November, 1992.

8. HEALTH NET denied Plaintiff's request for coverage of HDCT/ABMT in November 1992 on the basis that the procedure was investigational as defined under the plan.

9. Plaintiff, DONNA DURHAM, made a second request to HEALTH NET for coverage of HDCT/ABMT on or about March 1993.

10. HEALTH NET denied Plaintiff's request for coverage of HDCT/ABMT in March 1993 on the basis that the procedure was not medically necessary for her.

11. Plaintiff's HEALTH NET coverage under COBRA ended on December 31, 1993.

12. Plaintiff did not undergo the HDCT/ABMT at any time.

13. Plaintiff did not incur any cost associated with receipt of HDCT/ABMT at any time.

14. This action arises under the Employee Retirement Income Security act of 1974 ("ERISA"), 29 U.S.C. §1001, *et seq.* and Plaintiff seeks damages as set forth in her First Amended Complaint on file herein.

15. Plaintiff, DONNA DURHAM, is not presently a candidate for HDCT/ABMT.

LEIBOVIC & TYSCH

Dated: 5-15-95

By: /s/ Jodi L. Hochman
JODI L. HOCHMAN
Attorneys for Plaintiff,
DONNA DURHAM

VOGT, MEADVILLE & SWALLOW

Dated: 5-12-95

By: /s/ Firouzeh Liann Gohari
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Attorneys for Defendant,
HEALTH NET

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

DONNA DURHAM, Plaintiff, vs. HEALTH NET, Defendant.	)	No. C-94-3575 MHP **MEMORANDUM AND ORDER** ENTERED IN CIVIL DOCKET JUL 10 1995

Plaintiff Donna Durham brought this action against defendant HEALTH NET alleging breach of fiduciary duty under the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.* ("ERISA"), and seeking plan benefits or equitable relief. Now before the court are cross-motions for summary judgment on the issue of whether Durham is entitled to any relief under ERISA.

Having considered the parties' arguments and submissions, and for the reasons set forth below, the court enters the following memorandum and order.

BACKGROUND[1]

Defendant Health Net provides group health care coverage. Plaintiff Donna Durham became a participant in a Health Net plan on January 1, 1992 while she was an employee of Restaurant Enterprises Group, Inc. Durham's employment was terminated on June 15, 1992,

[1] Unless otherwise indicated, the following facts are taken from undisputed portions of the record.

but she elected to continue her Health Net coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). The health plan in dispute is governed by ERISA.

Donna Durham was diagnosed with breast cancer on September 14, 1992. She alleges that her physicians recommended an aggressive cancer treatment consisting of high dose chemotherapy in conjunction with autologous bone marrow transplants/peripheral stem cell reinfusion (hereinafter "HDCT-ABMT"). She was a candidate for this treatment for only a short window of time. In November 1992, Health Net denied Durham's application for coverage of HDCT-ABMT on the grounds that the treatment was "experimental" and "investigational." In March 1993, Health Net denied Durham's second request for coverage of HDCT-ABMT on the grounds that it was "not medically necessary." Durham did not obtain the treatment and is no longer a candidate for it.

Durham contends that Health Net's refusal to cover the procedure deprived her of the opportunity to obtain potentially curative and life-saving medical treatment. Durham alleges that Health Net's denial of coverage constitutes a breach of the plan contract and compels the imposition of compensatory or restitutionary damages. Health Net counters that it was justified in denying the coverage of the service on the grounds that it is an experimental treatment.

The threshold issue in this case is whether Health Net can be held liable for its refusal to cover the treatment if in fact its refusal was arbitrary and capricious. Durham argues that the civil enforcement section of

ERISA, section 502(a), 29 U.S.C. § 1132(a), allows for either compensatory damages in the amount of the treatment or restitutionary damages in the same amount. Health Net maintains that these damages are not available to plaintiff under ERISA.

LEGAL STANDARD

Under Federal Rule of Civil Procedure 56, summary judgment shall be granted "against a party who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial . . . since a complete failure of proof concerning an essential element of the nonmoving party's case necessarily renders all other facts immaterial." *Celotex Corp. v. Catrett*, 477 U.S. 317, 322-23 (1986); *see also T.W. Elec. Serv. v. Pacific Elec. Contractors Ass'n*, 809 F.2d 626, 630 (9th Cir. 1987) (the nonmoving party may not rely on the pleadings but must present significant probative evidence supporting the claim); *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986) (a dispute about a material fact is genuine "if the evidence is such that a reasonable jury could return a verdict for the nonmoving party.").

The court's function, however, is not to make credibility determinations, *Anderson*, 477 U.S. at 249, and the inferences to be drawn from the facts must be viewed in a light most favorable to the party opposing the motion. *T.W. Elec. Serv.*, 809 F.2d at 631.

It is beyond peradventure that summary judgment is appropriate where the issue before the court is purely legal in nature. *See* Fed. R. Civ. P. 56.

DISCUSSION

ERISA broadly preempts state law. The specific language of ERISA, its structure and its legislative history make clear that Congress intended to establish employee benefit plan regulation as an exclusively federal concern. *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985).

The civil enforcement section of ERISA is found in section 502(a). The Supreme Court noted that when a statute expressly details the remedies available, a court may not create further forms of relief that Congress did not intend. *Russell*, 473 U.S. at 145. The six actions allowed by this section are thus the exclusive remedies available to participants of plans governed by ERISA. *Id.* at 146.

Congress had a dual purpose in enacting ERISA, consisting of both the protection of plan participants and the fostering of employee benefit plans. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987). The specific remedies available for civil actions under ERISA achieve a balance between these two purposes; they allow participants equitable remedies to receive the benefits to which they are entitled while ensuring that the providers of employee welfare plans are not deterred from offering the plans due to the threat of unlimited liability.

I. BENEFITS

Durham contends that because she is no longer a candidate for HDCT-ABMT, she is entitled to the cost of the treatment pursuant to section 502(a)(1)(B), 29 U.S.C.

§ 1132(a)(1)(B). Health Net responds that she would only be entitled to this remedy if she had actually incurred the cost by funding the treatment herself and that the only other relief she can seek under this section is an injunction or declaratory judgment.

Section 502(a)(1)(B) provides:

> A civil Action may be brought –
>
> (1) by a participant or beneficiary –
>
> . . .
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

29 U.S.C. § 1132(a)(1)(B). The Supreme Court has interpreted this section of ERISA to allow for only three specific types of relief: disbursement of accrued benefits, a declaratory judgment that the participant is entitled to benefits under the provisions of the plan contract, and an injunction to prevent the plan administrator from wrongly refusing to pay benefits in the future. *Russell*, 473 U.S. at 147. Health Net is correct that Durham can seek only these three specific remedies under section 502(a)(1)(B).

Durham contends that she is entitled to recover the monetary value of the HDCT-ABMT because the treatment constitutes a "benefit" which she is entitled to recover. She argues that now that she is no longer a candidate for the treatment, Health Net should be held liable for the cost of the treatment as an alternative to specific performance. However, the benefit referred to in

this section of ERISA consists either of the accrued costs of the benefit or the benefit itself. *Id.* Because Durham did not obtain the treatment, she has not accrued recoverable costs. Because she is no longer a candidate for the treatment, she cannot obtain the treatment as a form of relief.

It is important to note that Durham was not left without legal recourse if indeed she was wrongly denied benefits. She had the option of obtaining an injunction or a declaratory judgment to receive the HDCT-ABMT treatment during the time that it would have benefitted her. Now that she is no longer a candidate for the treatment, however, she does not have legal recourse under section 502(a)(1)(B).

II. RESTITUTION

Durham argues that because it wrongfully denied coverage of HDCT-ABMT, Health Net has been unjustly enriched in the amount of the treatment and that she is entitled to sue for restitution under 502(a)(3)(B)(i) and (ii), 29 U.S.C. § 1132(a)(3)(B)(i) and (ii). Health Net responds that the remedies in this section apply only to suits that intend to benefit the plan as a whole and not to individual actions.

Section 502(a)(3)(B)(i) and (ii) provide:

A civil action may be brought –

> (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress

> such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.

29 U.S.C. § 1132(a)(3)(B). Durham is correct that "other appropriate equitable relief" encompasses restitution.[2] *Mertens v. Hewitt Assoc.*, ___ U.S. ___, 113 S. Ct. 2063, 2068 (1993). However, the remedies in this section apply only to suits brought on behalf of the entire plan, and not to suits brought to compensate individuals. *Sokol v. Bernstein*, 803 F.2d 532, 536 (9th Cir. 1986). Because Durham is initiating an action purely on her own behalf and not for the plan as a whole, she cannot seek restitution under section 502(a)(3).

Durham cites *Warren v. Society National Bank*, a Sixth Circuit case, to support her claim for restitution. In fact, the Sixth Circuit is the only circuit that has allowed individual recovery under Section 502(a)(3). *Warren v. Society National Bank*, 905 F.2d 975, 980 (6th Cir. 1990). The Ninth Circuit has expressly held that this section limits recovery to actions that are brought on behalf of the plan as a whole. *Sokol*, 803 F.2d at 536. In this jurisdiction, Durham is unable to recover individual relief under section 502(a)(3).

Durham cites two cases to indicate that other district courts have granted equitable relief to plaintiffs under ERISA. However, in each of these cases the plaintiff

---

[2] Durham's argument that Congress intended to incorporate the fiduciary standards of trust law into ERISA is no longer required to reach the conclusion that restitution is an available remedy under section 502(a)(3) since the Supreme Court expressly acknowledged this point in *Mertens*.

sought and was granted an injunction ordering her insurer to provide coverage for HDCT-ABMT. *Kekis v. Blue Cross and Blue Shield of Utica-Watertown, Inc.*, 815 F. Supp. 571 (N.D.N.Y. 1993); *White v. Caterpillar, Inc.*, 765 F. Supp. 1418 (W.D. Mo. 1991). As noted previously, Durham is also entitled to injunctive relief under section 502(a)(1)(B), but she cannot pursue it as a form of relief now that she is no longer a candidate for the treatment.

CONCLUSION

For the foregoing reasons, the court hereby GRANTS Defendant's motion for summary judgment and DENIES Plaintiff's motion for summary judgment.

IT IS SO ORDERED.

Dated: JUN 22 1995 /s/ Marilyn Hall Patel
MARILYN HALL PATEL
United States District Judge

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

DONNA DURHAM,
Plaintiff,
vs.
HEALTH NET,
Defendant.

No. C-94-3575 MHP

JUDGMENT

(Filed Jun. 29, 1995)

ENTERED IN CIVIL DOCKET JUL. 10 1995

This action having come before this court, the Honorable Marilyn Hall Patel, United States District Judge presiding, and the issues having been duly presented and an order having been duly filed,

IT IS ORDERED AND ADJUDGED that plaintiff's motion for summary judgment is DENIED and defendant's motion for summary judgment is GRANTED and this action is dismissed in its entirety.

IT IS SO ORDERED.

DATED: JUN 29 1995

/s/ Marilyn Hall Patel
MARILYN HALL PATEL
United States District Judge

UNITED STATES CODE ANNOTATED
TITLE 29. LABOR
CHAPTER 18 – EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM
SUBCHAPTER 1 – PROTECTION OF EMPLOYEE BENEFIT RIGHTS
SUBTITLE B – REGULATORY PROVISIONS
PART 5 – ADMINISTRATION AND ENFORCEMENT

§ 1132. Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought –

(1) by a participant or beneficiary –

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain

other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), or (5) of subsection (c) of this section or under subsection (i) or (1) of this section;

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 1169(a)(2)(A) of this title);

(8) by the Secretary, or by an employer or other person referred to in section 1021(f)(1) of this title, (A) to enjoin any act or practice which violates subsection (f) of section 1021 of this title, or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection; or

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this subtitle or the terms of

the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts.

Supreme Court, U.S.
FILED
JUN 13 1997
OFFICE OF THE CLERK

No. 96-1802

In The

Supreme Court of the United States

October Term, 1996

DONNA DURHAM,

Petitioner,

vs.

HEALTH NET, a California Corporation, THE RESTAURANT ENTERPRISES GROUP INC. EMPLOYEE BENEFIT PLAN, *et al.*,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

RESPONDENTS' BRIEF IN OPPOSITION

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22 pp

QUESTIONS PRESENTED FOR REVIEW

1. Does the failure to seek injunctive relief available under ERISA to secure medical treatment at a time when medically eligible preclude a later filed claim that seeks to invoke *Varity Corp. v. Howe*, 516 U.S. __, 116 S. Ct. 1065 (1996) to recover the money value of medical treatment that was never obtained?

2. Are the ERISA remedies that are available for injunctive relief to secure medical treatment so inadequate as to allow a later filed claim under *Varity Corp. v. Howe*, 516 U.S. __, 116 S. Ct. 1065 (1996) to recover the money value of medical treatment that was not obtained?

3. Does ERISA authorize a private right of action against an HMO to recover the dollar value of medical treatment that was never obtained and for which the beneficiary subsequently became medically ineligible?

4. Does ERISA authorize a private right of action to recover money measured as the dollar value of medical treatment that was not obtained by re-labeling the request for money damages as seeking "restitution" or other forms of "equitable relief"?

5. Is Petitioner's claim for injunctive relief moot?

STATEMENT OF INTERESTED PARTIES

Pursuant to Rule 29.6, Rules of the Supreme Court of the United States, Respondents hereby identify Health Systems International, Inc. ("HSI"), a public company traded on the New York Stock Exchange ("NYSE"), as the parent company of Respondent Health Net during the proceedings in the Ninth Circuit below. Since the Ninth Circuit's decision HSI has merged with another publicly traded company, Foundation Health Corp. The merged entity, which is Health Net's ultimate parent corporation, is now known as Foundation Health Systems, Inc. and is traded on the NYSE. The nonwholly owned subsidiaries of Foundation Health Systems, Inc. are San Luis Valley Physicians Service Corp., Limited, a Colorado corporation; QualMed Plans for Health of Pennsylvania, a Pennsylvania corporation; Integrated Pharmacy Systems, Inc., a Pennsylvania corporation; Foundation Health (Unlimited), United Kingdom; Mednet Europe, United Kingdom; and Gem Holding Corporation, a Utah corporation. The other respondent, The Restaurant Enterprises Group Inc. Employee Benefit Plan is a private employee welfare benefit trust. Petitioner, Ms. Donna Durham, is an individual residing in Northern California. No other parties appeared in the case in the District Court or on appeal.

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Other Authorities Cited:

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R. Stern, E. Gressman, S. Shapiro & K. Geller, Supreme Court Practice (7th Edition 1993) 9

STATEMENT OF THE CASE

A restatement of the case is in order because Petitioner's rendition of the facts leaves out many details crucial to understanding the case and contains other assertions that are not supported in the record. As Petitioner has not seen fit to support her version of the "facts" with citation to the record, pursuant to Rule 12.7 of the Court Respondents cite the record on appeal using the same notation used in the Ninth Circuit.

The salient facts are few. Petitioner became a member of the Health Net health care service plan (hereinafter "Health Net") in January 1992. (CR 22, ER 1, ¶ 1)[1]. Her membership was through participation in the Restaurant Enterprises Group Inc. Employee Benefit Plan (hereinafter "Employee Plan") which was a fringe benefit provided through her employment. (CR 22, ER 1, ¶ 2). Her employment ended June 15, 1992, and she continued receiving medical benefits from Health Net through December 31, 1993, under COBRA[2]. (CR 22, ER 2, ¶¶ 4 & 5).

As a health maintenance organization (hereinafter "HMO"), Health Net provides health care benefits in a different manner than the traditional "health insurer" who provides indemnity insurance for health care treatments. An HMO operating under the "network" model like Health Net contracts with medical groups who in turn provide medical care. Rather than money,

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1. The abbreviations "CR," "RT," "ER," and "SER" are used throughout to refer to the Clerk's Record (District Court Docket Summary), the Reporter's Transcript of the hearing on the summary judgment, the Excerpts of Record submitted by the Appellant in the Ninth Circuit, and the Supplemental Excerpts of Record submitted by the Appellees, respectively. Citations have been omitted and emphasis added in quotations unless otherwise noted.

2. The Consolidated Omnibus Budget Reconciliation Act of 1985, codified, as amended, at 29 U.S.C. §§ 1161-68.

the HMO provides access. It is a vehicle through which the beneficiary obtains health care treatment. The benefit contract with the HMO commits it to make access available for certain care and procedures through participating physicians and hospitals. If the member wants to partake of the benefits provided through Health Net, the member must use the health care providers and facilities within Health Net's "network." Generally, services received "out-of-network" are not within the scope of Health Net's "coverage." Thus, the benefits provided through Health Net are access to the medical treatments furnished to the member by the medical groups and facilities with which Health Net has contracted, not payment for care or reimbursement for care as are provided to the insured under health insurance.

HMOs like Health Net are heavily regulated by the State of California. All aspects of the operation of an HMO operating in California are actively monitored and continually regulated by the California Commissioner of Corporations and Department of Corporations (hereinafter "DOC"), not the Insurance Commissioner or the Department of Insurance. Cal. Health & Safety Code § 1340, *et seq.*; Cal. Insurance Code § 740(g) (Insurance Code inapplicable to HMOs). Among the aspects regulated by the DOC are the marketing of the HMO to employer groups and to prospective members; the contracts with the physicians, hospitals and providers utilized by the HMO to provide health care; and the finances of the HMO. Since January 1, 1996, the DOC has also been charged with providing a forum for review of disputes over individual health care benefit decisions. Cal. Health & Safety Code § 1368 as amended, 1995 Laws, 788 (Oct. 12, 1995). In addition, the California Legislature has defined the minimum package of health care benefits that must be provided by an HMO operating in California. Cal. Health & Safety Code § 1367, *et seq.* High dose chemotherapy treatment/autologous bone marrow transplant (hereinafter

"HDCT/ABMT") is not among the benefits that are required to be provided. Of course, HMOs like Health Net can and do contract to provide more than the minimum benefits package required.

On September 14, 1992, petitioner was diagnosed with breast cancer. (CR 22, ER 2, ¶ 6). She requested authorization from Health Net for HDCT/ABMT in November, 1992. (CR 22, ER 2, ¶ 7). The request was denied. (CR 22, ER 2, ¶ 8). Petitioner made a second request for authorization in March, 1993. (CR 22, ER 2, ¶ 9). This request was also denied. (CR 22, ER 2, ¶ 10).

Petitioner did not file suit to seek to compel Health Net to provide HDCT/ABMT. (CR 35, SER 1-13). Nor did she seek to undergo HDCT/ABMT at her own expense, and she did not incur *any* cost in connection with HDCT/ABMT. (CR 22, ER 2, ¶¶ 12 & 13). Subsequently, her condition changed and HDCT/ABMT was not medically indicated.[3] (CR 22, ER 3, ¶ 15). Her cancer is now in remission, and only monitoring is medically indicated. (CR 35, SER 17:12-22, RT at 14:12-22). She is not presently a candidate for HDCT/ABMT treatment, and was not at the time she filed suit. (CR 22, ER 3, ¶ 15).

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3. The unsworn assertions made at footnote 3 of the Petition that Ms. Durham's cancer has reappeared are not in the record and cannot be considered here. Moreover, skepticism is in order for several reasons. At oral argument in the Ninth Circuit Mr. Tysch asserted this had coincidentally happened as well in the companion case consolidated for argument. Counsel's penchant for citing "unsworn averments in a memorandum of law" has been judicially recognized, and such statements disregarded, elsewhere. *See Davenport v. Blue Cross of California*, 52 Cal. App. 4th 435, 454; 60 Cal. Rptr. 2d 641, 651-52 (1997). That court also noted additional issues presented to it regarding claims of counsel's problems complying with court rules regarding evidence and his obligations as an officer of the court. *Id.* at 52 Cal. App. 4th at 442 & fn. 1, fn. 2; 60 Cal. Rptr. 2d at 644 & fn. 1, fn. 2.

Despite the fact that HDCT/ABMT was no longer of any use to her, and despite the fact that she never paid for HDCT/ABMT treatment from other sources, petitioner sought monetary damages as set forth in the First Amended Complaint. (CR 16, SER 8, ¶¶ 24, 28, 30 & 37).

Procedurally, the suit started in March, 1994 in California Superior Court and was removed to District Court. (CR 1, ER 21, ¶ 16). The amended federal court complaint had three counts: (1) a breach of contract claim; (2) a claim for "equitable relief"; and (3) a claim for attorneys' fees. (CR 16, SER 1-13). At an early status conference the District Court invited the parties to address by summary judgment the issue whether the relief sought was available under ERISA. The District Court concluded it was not, and granted Health Net's motion for summary judgment. As the claims against the Employee Plan were premised on the claims against, and the relief sought from, Health Net, judgment was entered dismissing the case. Petitioner appealed and the Ninth Circuit affirmed. The matter is now before this Court on Petition for Certiorari.

REASONS FOR DENYING THE WRIT

I.

THERE IS NO DIRECT AND APPARENT CONFLICT BETWEEN THE *VARITY* DECISION AND THIS CASE.

Petitioner seeks review of the "conflict" between this case and the Court's recent decision in *Varity Corp. v. Howe*, 516 U.S. __, 116 S. Ct. 1065 (1996). However, that case is wholly distinguishable from the instant case, and there is no "conflict". Moreover, there has been no showing that the purported "conflict" is both direct and apparent. Finally, review by the Court should not be squandered on a case of this nature — an

unpublished decision concerning the accuracy of an individual health benefit determination.

A. *Varity* Is Distinguishable And The Court's Decisions In Cases Like *Russell, Mertens,* And *Pilot Life* Apply.

1. *Petitioner Seeks Damages, Not Equitable Relief*

The decision in *Varity Corp.* is distinguishable on several grounds. First, what Ms. Durham seeks is not equitable relief but compensatory damages. Her ERISA complaint below had three counts: breach of contract, "equitable relief" and a claim for attorneys' fees. The relief sought was an award of the monetary value of the HDCT/ABMT. No claim of breach of fiduciary duty was made[4] and no specific relief other than an order for the payment of money was ever raised. That is what was requested in both the District Court and on appeal. The only relief that Petitioner ever identified or requested was that Respondents be ordered to pay money to Petitioner in the amount of the value of the medical treatment benefit they claim was wrongfully denied. While Petitioner has called this "restitution," "disgorgement" of "unjust enrichment," "constructive trust" and now just "equitable relief," the Court of Appeals found the relief sought was a claim for "compensatory damages." That mixed ruling of law and fact provides a valid distinction from *Varity.* It is also consistent with the Court's decision in *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41 (1987) which held there is no private right of action under ERISA to recover money for improper claims handling including that arising from delay in a benefits decision. Moreover, even assuming the Ninth Circuit erred in ruling that petitioner's claim was one for compensatory damages, the ruling does not provide the direct and apparent conflict that

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4. At oral argument on the summary judgment motions, in response to questioning by the Court, Petitioner clearly stated she was not making a claim based on alleged breach of fiduciary duty. RT at 2:18-3:10.

Rule 10(c) requires to merit the Court's review. Rather, it is a ruling that is fact-dependent and case-specific.

B. The Court's Decision In *Russell*, Distinguished In *Varity*, Governs This Case.

The result below is consistent with and controlled by the Court's decisions in *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985) and *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993), which in turn were distinguished by the Court in arriving at its decision in *Varity*. In *Varity* the Court noted that:

> *Russell* involved a complicating factor not present here, in that another remedial provision (subsection one) already provided specific relief for the sort of injury the plaintiff had suffered (wrongful denial of benefits). . . .

Varity, 516 U.S. at __, 116 S. Ct. at 1076.

That distinction holds here as well. This case is about a denial of benefits plain and simple. Petitioner had a remedy under Section 502(a)(1) of ERISA (codified at 29 U.S.C. § 1332(a)(1)) to contest the denial of benefits at the time and to seek an order directing Health Net to authorize coverage for the treatment at issue. Despite having ample time to bring a suit for injunctive relief compelling Health Net to reverse its decision, Petitioner did nothing until filing suit more than a year and a half after the initial denial by Health Net. By then injunctive relief was moot as Petitioner's cancer was in remission. Petitioner now seeks equitable relief pursuant to 29 U.S.C. § 1132(a)(3) as interpreted by *Varity*. However, where section

1132(a)(1) provides an adequate remedy, equitable relief under section (a)(3) is inappropriate.[5]

C. Even Assuming *Varity* Applied, The Question Of Appropriate Equitable Relief Is Not Squarely Presented.

Petitioner argues that the conflict is so squarely presented as to justify review. In fact, even assuming *arguendo* that *Varity* applies, the remedy sought in this case is not available under the holding in that case. In any event, the "absence" of a remedy in the instant case does not "squarely present" a mandate for fashioning a remedy here. *Varity* authorizes only "appropriate equitable relief." *Varity*, 516 U.S. at ___, 116 S. Ct. at 1079. Thus, the Court noted that:

> [W]here [as here] Congress elsewhere provided adequate relief for a beneficiary's injury, there will likely be no need for further equitable relief, in which case such relief normally would not be "appropriate." *Cf. Russell, supra*, at 144.

Id.

Here, the further relief sought is not appropriate in view of the remedy that was available and unused for anywhere from five to eighteen months. Moreover, injunctive relief for the denial of benefits is moot. Sometime over the year and one-half period between the benefit denial decision and the filing of suit, Petitioner's cancer was in remission and injunctive relief became moot. On the record of this case, at all times from initiation of suit Petitioner has been medically ineligible for the treatment at

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5. Indeed, the Ninth Circuit has recognized this holding of *Varity*. *Forsyth v. Humana, Inc.*, 1997 WL 271465 (9th Cir. (Nev.)).

issue.[6] Moreover, as Petitioner had left her employment before the initial diagnosis of breast cancer and thereafter terminated her health plan coverage, there is no basis on which Health Net and the ERISA plan could be currently ordered to authorize treatment to someone no longer participating in the ERISA health plan. Any injunctive relief was moot once her cancer was in remission and she left the plan. Therefore, there is no remedy "appropriate" under *Varity*.

II.

IT IS NOT THE COURT'S ROLE TO REVIEW UNPUBLISHED DECISIONS FOR ERRORS IN INDIVIDUAL ERISA BENEFIT DETERMINATIONS.

Review by this Court is a scarce resource. Over the years the Court has developed an extensive jurisprudence regarding the exercise of its discretion regarding which cases to review.

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6. Even assuming the new "facts" advanced in footnote 3 of the Petition, the case is still moot. Under California law any reappearance of Petitioner's cancer is the basis for a new health benefits claim under the coverage she then has. Of course, as Petitioner left her employment prior to the initial diagnosis of cancer she could not continue her coverage under the ERISA plan past the point decreed under COBRA. We do not know whether or not she had other coverage after that point. Under California's current law, had she sought conversion coverage she could not be precluded from joining a health plan based on her "pre-existing condition." Cal. Ins. Code § 10198.7. Once new coverage was in place, the reappearance of her cancer, if indeed it occurred, would have been dealt with as a new claim by the health insurer or HMO, if any, then providing coverage. The legal claim for injunctive relief sought in March 1994 as to the payment of the value of the treatment based on the benefit claim that was initially denied in November 1992 is still moot. The alleged re-appearance of cancer in late 1996 does not change the circumstance that at all times that she was covered by Health Net and the ERISA plan after the remission of her cancer, Petitioner was not medically eligible for HDCT/ABMT treatment.

This case does not satisfy any of the criteria for grant of *certiorari*. There are no "special and important reasons" to review this case. Rule 10, Rules of the Court. The Petition should be denied for this reason alone.

The sole basis advanced for review is that the Ninth Circuit's unanimous unpublished decision has been decided in "conflict" with a decision of the Court. Even assuming for the sake of argument that there were such a conflict, there has been no showing that the conflict concerns "an important federal question." Rule 10(c), Rules of the Court. There is also considerable doubt whether an unpublished ruling, which is not even binding precedent in the Ninth Circuit[7], can ever rise to the nature of the conflicting decision that is contemplated to fit within Rule 10(c). The function of this Court has never been to review unpublished Court of Appeal decisions to correct claimed deviations from decisions of the Court. Rather, review under Rule 10(c) requires "conflict" that is both "direct and apparent." R. Stern, E. Gressman, S. Shapiro & K. Geller, Supreme Court Practice (7th Edition 1993) at p. 174. The underlying premise of that standard and the Rule is that the decision to be reviewed will cause on-going problems in the lower courts if not addressed by the Court. Here, there will be no on-going problems with the application of the Court's decision in the Ninth Circuit or elsewhere. It is not a legal precedent and cannot be cited in any other case.

Respondents submit there are no special and important reasons for granting the Petition. It is not the function of this Court to review the accuracy of a denial of an individual ERISA medical benefit claim set forth in an unpublished Court of Appeals decision. One principle on which the Court operates is that the fact that a case "may have been wrongly decided as

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7. Ninth Circuit Rules, Rule 36-3.

between the parties" is not enough.[8] That should be doubly the case where the error concerns the case-specific question of the availability of equitable relief set out in an unpublished decision. The Petition should be denied.

III.

THE RELIEF PETITIONER SEEKS IS CONTRARY TO ERISA'S "CAREFULLY INTEGRATED" CIVIL ENFORCEMENT SCHEME.

ERISA is a " 'comprehensive and reticulated statute,' the product of a decade of congressional study . . . ."[9] Both the "remedies created by ERISA and the parties expressly authorized to seek them [are] exclusive."[10] The statutory scheme sets forth "six carefully integrated civil enforcement provisions."[11] Petitioner's arguments for review are premised on a mistaken, overly expansive reading of *Varity*.

The claimed "conflict" with *Varity* hinges on the "inadequate" remedy and the contention that *Varity* allows "the fashioning of appropriate equitable relief . . . where no other adequate relief is otherwise available." Petition at p. 5. That is not an accurate reading of *Varity*. If it were, *Varity* would be a license to re-write the ERISA remedial scheme. Petitioner's argument boils down to the proposition that whenever a litigant in a particular case finds the ERISA remedial provisions stand

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8. Justice Harlan, *Manning the Dikes*, 13 Record of N.Y.C. Bar Assn. 541, 551 (1958).

9. *Mertens, supra*, 508 U.S. at 251.

10. *Pilkington PLC v. Perelman*, 72 F.3d 1396, 1398 (9th Cir. 1995).

11. *Russell, supra*, 473 U.S. at 146.

in the way of a particular item of relief (here the award of the monetary value of a benefit denied), the Court is free to invoke a "catchall" provision and "fashion appropriate equitable relief" to give the litigant what he or she wants. Not only does this run contrary to a number of the Court's decisions never mentioned in the Petition such as *Russell* and *Mertens*, but it also usurps the congressional function to set ERISA's remedial scheme. This improper invitation to re-write the statute is another reason for denying the writ.

With respect to benefit denials, Congress intended plan beneficiaries to resort to the remedy in Section 502(a)(1) (codified at 29 U.S.C. § 1132(a)(1)). Thus, it created a right to seek an immediate injunction in District Court and authorized the District Court to award attorneys' fees to further enhance and to encourage the use of this remedy. Under the interpretation of *Varity* urged by Petitioner, the Court should ignore all of the congressional study, the contours of Section 502(a)(1), and all of the Court's previous decisions regarding ERISA remedies and roam free to create additional remedies whenever it finds the congressional scheme "inadequate." Not only is no authority, other than *Varity*, advanced for this bold proposition; but none of the Court's other decisions, such as *Russell* or *Mertens* is even cited in the Petition. *Varity* does not grant such wide-ranging authority.

Petitioner's misinterpretation of *Varity* is highlighted by what is requested in this case. Petitioner, who slept on her rights and did not use the remedy Congress specifically provided, wants the Court to thereby conclude that a remedy for her claim is "unavailable" and "inadequate." That is not the holding of *Varity*.

Under the remedial schema intended by Congress she should have sought injunctive relief sometime in 1992 or 1993 to overturn the benefit decision. Congress made this remedy

"available," and, as Congress limited it, it must be deemed "adequate."

The specifics of the relief requested, a monetary award of the value of the treatment, also highlight Petitioner's misreading of *Varity*. To allow the lack of such relief to create a "conflict" with *Varity* would put *Varity* itself in direct conflict with a number of decisions of the Court. This Court has unequivocally held that Congress did not intend to grant compensatory damages for erroneous benefit decisions. *Mertens v. Hewitt, supra,* 508 U.S. at 255-259. It intended to provide an avenue to secure the benefits and no more. *E.g., Pilot Life Ins. Co. v. Dedeaux, supra,* 481 U.S. at 52. For the Court to nonetheless grant review to embark on a hunt for an "adequate" remedy every time this statutory scheme precludes an item of relief sought is neither an accurate reading of *Varity* nor a wise use of the *certiorari* jurisdiction. Furthermore, to invoke it in the circumstances of this particular case is not a sound exercise of the discretion to grant the writ. The Petition should be denied.

IV.

THE RESULT BELOW WOULD NOT IMMUNIZE ERISA VIOLATIONS AND LEAVE HEALTH PLAN MEMBERS WITHOUT REDRESS.

The focal point of the Petition is the claim that absent Court review and reversal there is no remedy for Petitioner, and this creates an unbearable "conflict" with *Varity*. The argument is made that this lack of remedy and conflict require the Court to fashion an equitable remedy. In fact, the disposition by the Court of Appeals does not leave HMO members who cannot afford to advance the costs of treatment with no remedy under ERISA.

There is a remedy under the statute for HMO members who

believe they are wrongfully denied benefits, whether the denial be perceived to be life threatening or otherwise. The remedy is for the member to sue promptly under 29 U.S.C. § 1132(a)(1) for an injunctive order to compel the plan to provide the medical treatment. Indeed, this avenue of redress is of more than theoretical substance as reported decisions suggest it has been used frequently. *E.g., Barnett v. Kaiser Foundation Health Plan, Inc.*, 32 F.3d 413 (9th Cir. 1994) (expedited trial regarding denial of liver transplant); *Bernards v. United of Omaha Life Ins. Co.*, 987 F.2d 486 (8th Cir. 1993) (ABMT denial; expedited summary judgment); *Kekis v. Blue Cross and Blue Shield of Utica-Watertown, Inc.*, 815 F. Supp. 571 (N.D.N.Y. 1993) (ABMT denial; preliminary injunction sought); *White v. Caterpillar, Inc.*, 765 F. Supp. 1418 (W.D. Mo. 1991), *aff'd without opinion*, 985 F.2d 564 (1991) (ABMT denial; preliminary injunction sought); *Sweeney v. Gerber Products Co. Med. Benefits Plan*, 728 F. Supp. 594 (D. Neb. 1989) (ABMT denial; preliminary injunction sought and combined with trial on the merits).

Contrary to Petitioner's assertion below that lawyers will not take such cases unless there is the added incentive that her claim for monetary relief will provide, lawyers have and will continue to pursue these cases. *E.g., Barnett, supra; Bernards, supra; Kekis, supra; White, supra; Sweeney, supra.* Congress has provided that such plaintiffs may recover attorneys' fees in appropriate cases, and any argument that this incentive is not enough should be addressed to Congress, not the courts. Denying the Petition will not leave ERISA beneficiaries without a remedy and will not create incentives for HMOs to wrongfully deny benefits. In sum, there is no good reason why "equity" considerations, whether they be general or specific to this case, should lead to review based on a conflict with *Varity*.

The District Court was aware of this avenue of redress and questioned Petitioner's counsel about it during argument on the

summary judgment motion. (CR 22, SER 20:21-21:27, RT at 19:21-20:7). As the record there reveals, petitioner had a period of at least five months where this remedy was open to her.[12] As there is no evidence in the record how long after March 1993 this "window" closed, the actual time might have been as long as a year and a half. No explanation was or could be given that this opportunity was insufficient. It is what the statute provides, and this Court should not create an additional, unauthorized remedy.

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12. As argued below, petitioner slept on her rights from at least November 1992. (CR 22, SER 18:14- 19:11, RT 15:14- 16:11). The record shows that there was a period from at least November 1992 through March 1993 that she could have brought and resolved a claim for injunctive relief. *Id.* Approximately one and a half years later she brought the instant suit.

CONCLUSION

Based on the foregoing, the Petition for a Writ of Certiorari should be denied.

Respectfully submitted,

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